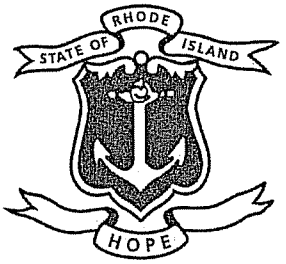

Office of Health Insurance Commissioner **Department of Human Services**

June 3, 2008

The Honorable Donald L. Carcieri
Governor
State House 222
Providence, RI 02903

The Honorable Elizabeth H. Roberts
Lieutenant Governor
State House 116
Providence, RI 02903

Dear Governor Carcieri and Lt. Governor Roberts:

In response to your charge, we convened the Community Hospital Task Force between November, 2007 and April, 2008 in order to examine Medicaid payment methodology and other issues related to systemic changes in payment, health planning, and financial analysis. The enclosed report is the summary of the Task Force's discussion and recommendations, as prepared by the Co-Chairs with extensive participation and feedback from members of the Community Hospital Task Force.

The recommendations included in this report were put to a formal vote on April 28th and supported by a majority of Task Force members present at the meeting. The report itself is the product of an energetic review and commenting process, and attempts to capture the range of opinions present in the task force. Over the course of their work Task Force members debated vigorously on key issues such as the specifics of Medicaid payment redesign and oversight of hospital/health plan negotiation process, transparency of hospital payment rates, and short-term hospital stabilization options. While general agreement was reached among some members on specific issues, there was rarely universal support for any policy position or recommendation.

It should be noted that repeatedly the Task Force was drawn from the specific charge it was given regarding Medicaid and commercial insurance payment mechanisms for community hospitals, to broader policy questions regarding the hospitals, their future roles and their treatment. Similarly, the Task Force more readily agreed on problematic symptoms community hospitals face than on appropriate cures – most notably in how they negotiate payment rates with insurers.

Thus, as the report concludes, it is a description of a variety of policy options that may serve as the basis for continuing dialogue. It prioritizes but does not resolve the more fundamental issues regarding

the future roles of community hospitals in the Rhode Island medical services delivery system. It is our observation as Co-chairs that, while it has worked diligently and in good faith, the Task Force as currently constructed may lack the analytical resources, the direction and a broad-based membership to accomplish these broader goals.

We would be pleased to meet with you to discuss the findings and process of the Task Force at your convenience. Thank you for the opportunity to serve in this role.

Sincerely,

Christopher F. Koller
Health Insurance Commissioner

Gary D. Alexander
Director, Department of Human Services

Report of the Community Hospital Task Force

Presented to:

Hon. Donald L. Carcieri, Governor, State of Rhode Island
&
Hon. Elizabeth H. Roberts, Lt. Governor, State of Rhode Island

June 3, 2008

Prepared by the co-chairs of the Community Hospital Task Force:
Gary D. Alexander, Director, Department of Human Services
Christopher F. Koller, Health Insurance Commissioner

With participation from Task Force members

- Fred Allardyce and David Nolf (alternate), Board Members, Westerly Hospital
- Senator Stephen D. Alves, chairperson, Senate Committee on Finance
- J. Russell Corcoran, MD, FACP, (Internist)
- Representative Steven M. Costantino, chairperson, House Committee on Finance
- Andrew M. Erickson, Board Member, Kent Hospital
- Louis Giancola, CEO, South County Hospital
- David R. Gifford, MD, MPH, Director, Department of Health
- Herb Gray, Rhode Island Business Group on Health
- Sam Havens, Consumer
- Bernadette Hawes, Consumer
- Alicia Monroe, MD
- F Paul Mooney, Jr., Board Member, Memorial Hospital
- Senator Rhoda E. Perry, chairperson, Senate Committee on Health and Human Services
- BJ Perry, United Healthcare of New England
- James Purcell, CEO, Blue Cross Blue Shield of Rhode Island
- Daniel Ryan, Board Member, St. Joseph Health Services of Rhode Island
- Sharon Smith, RN, Member, State Board of Nursing; Surgical Nurse, Westerly Hospital
- Bruce Tucker, Board Member, Newport Hospital

Introduction

This report summarizes the Community Hospital Task Force's work in response to its charge given in November, 2007:

> The long-term charge to the Task Force is to recommend changes to health care payment methods used by all payers that realign incentives to promote high-quality and cost-efficient care. The Task Force's first step in this process is to examine principles for inpatient payment and options for Rhode Island's Medicaid program to implement a case-based inpatient payment methodology; then to examine how the recommendations for a case-based inpatient payment method for Rhode Island Medicaid may apply more broadly to other payers.

This charge was based on the initial Task Force recommendation to "reform payment to encourage efficient and high quality care, being mindful of the goal of affordable health care."[1] This recommendation, which came out of the Task Force's work between April and July 2007, further specified that:

> "The State should evaluate options for adopting a case-based payment methodology across all payers statewide that encourages efficiency, quality, and collaboration. Any revisions to payment should support ongoing efforts to create an affordable health care system."[2]

The Task Force, in the same report, provided more detailed aspects of this recommendation[3]:

> "*Principles*
> - Commercial insurers' methodology should be designed consistent with Medicaid and Medicare and implemented with community input, including EOHHS and OHIC involvement.
> - The new payment methodology should include pay-for-performance provisions.
> - Payment should support primary care infrastructure and realign incentives to remove any reimbursement bias for complex services. Changes in payment should ensure that incentives are sufficient to support low-complexity and preventive services that are effective contributors to health.
> - Changes in payment should be used to align financially the interests of hospitals and physicians and thus eliminate some of the competition between them.
>
> *Actions*
> - Medicaid's payment methodology should be revised by FY2010 or earlier.
> - Physician reimbursement levels and methods should be examined in the next several months."

[1] See "Report of the Community Hospital Task Force," July 27, 2007. Page 6. Available at: http://www.eohhs.ri.gov/taskforce/FinalReport.pdf
[2] See citation above, page 26.
[3] See citation above, page 26.

Early Task Force work
Between April and July 2007, Governor Carcieri and Lt. Governor Roberts convened the Community Hospital Task Force "to examine the current financial health of community hospitals and recommend reforms that can help ensure the continued delivery of core services to the community."

One of the reasons behind these financial troubles, the Task Force believed, was changing and inconsistent reimbursement methodologies among payers. This and other reasons were deemed too complex to be solved with short-term solutions. The Task Force concluded that the only sustainable approach to addressing hospitals' ongoing financial health is to make positive systemic changes in hospital structures, services and reimbursement.

Task Force members endorsed the following conclusion:

> "Unless systemic changes are made, most community hospitals will face continued financial trouble in the coming years. A few hospitals will face more difficulty in the next 2 years, and one community hospital is in dire financial trouble right now."[4]

Since the conclusion of the work of the initial Task Force, it appears that the financial plight of the eight community hospitals has worsened. A formal report documenting hospitals' financial performance in Fiscal Year 2007 awaits submission of audited financial from all hospitals and is expected to be published in June.

Along with other topics it studied, the Task Force found that the major payers in Rhode Island reimburse different hospitals using different methodologies and with different payment levels for like services. This requires hospitals to manage multiple financial incentives across patients depending on their payer. Some methods have incentives that promote more efficient and high quality care, while others do not. These led to the first Task Force's recommendation that subsequent work be focused on hospital payment methodologies – the starting point for current Task Force work.

An additional recommendation from the first Task Force report to examine physician reimbursement levels and methods was not addressed in current Task Force work.[5]

Current Task Force work
This report reflects the work that the Task Force did relevant to its specific charge when it was reconvened in November 2007, as well as other recommendations that the Task Force made to address the financial issues facing community hospitals. It bears emphasizing that several Task Force members continue to express concern that the charge given to this Task Force did not adequately address the future of community hospitals in Rhode Island, and that more work is needed separate from the financing issues addressed here, such as in the area of health systems planning.

[4] See citation above, page 9.
[5] See citation above, page 5.

Additionally, members of the Task Force pointed out that the current state budget crisis has produced budget proposals for state fiscal year 2009 that exacerbate the financial conditions which gave rise to this Task Force, and recommended that state officials address this issue.

The Task Force's first charge was to review Medicaid inpatient payment methodology to hospitals. Because Medicaid makes up a relatively small share of payments to most hospitals, changing Medicaid payment rates will not have a substantial effect on the financial issues that face community hospitals. Thus, some Task Force members advocated that Medicaid payment work only was germane for struggling community hospitals if it set the groundwork for commercial payment review and possible reform.

After completion of initial Medicaid work, the Task Force considered a range of options for commercial payment oversight and also considered other alternatives related to commercial payment, such as expanding transparency of commercial payment rates to hospitals.

Methods

Task Force members
The composition of the Task Force remained unchanged for the purposes of preparing this preliminary report, with a few exceptions. The retirement of former co-chair Jane Hayward and the focus of the Task Force's discussions led to a change in Task Force co-chairs.

Task Force meetings
The Task Force has met nine times between November 19th 2007 and April 28th 2008. Guest speakers from the federal Centers for Medicare & Medicaid Services (CMS) joined for one meeting, and additional presentations and facilitation was provided by Medicaid consultants from ACS (Kevin Quinn and Connie Courts) and by Thomas Miller, PhD, MBA, Assistant Professor of Health Policy and Management at Providence College. The Task Force recognizes and thanks them for their contributions.

Information reviewed
The Task Force benefited from existing studies of hospital inpatient payment methodologies and descriptions of current methodologies used by Medicare (the dominant payer for hospital inpatient stays in most hospitals), Medicaid, and commercial payers. All materials are available for review at the Office of the Health Insurance Commissioner's website (www.ohic.ri.gov).

General Findings

Current fee-for-service Medicaid payment methodology
The Task Force reviewed current Medicaid payment methodology. The key provisions of the current method are described in a discussion paper developed by ACS in December 2006 and readers are referred to that document.[6]

[6] See "Purchasing Hospital Inpatient Care in Rhode Island: Options for Improvement," December 15, 2006. Available at: http://www.ohic.ri.gov/Committees_communityhosptaskforce.php

Primer on DRG-based payment systems
The Task Force received an introduction on the goals, design and evolution of the Diagnosis Related Group (DRG) case-based payment system used by Medicare and about two-thirds of the other states' Medicaid programs. Copies of those background materials are available at the Office of the Health Insurance Commissioner's website.

Principles for payment methodology
After reviewing its charge, background materials and current Medicaid expenditures, the Task Force identified principles for the payment systems in general. At the Task Force's November 27th meeting, the following principles were ranked in order of priority when selecting a hospital payment methodology:

Strongest support
Fairness: The payment system results in similar payment for similar care.[7]
Quality / Value-based purchasing: The payment system rewards the provision of good quality inpatient care.

Mid-level support
Efficiency: The payment system rewards the efficient use of resources for the provision of inpatient health care services both within institutions and across the hospital system as whole.
Acceptability / Transferable to other payers: The payment system reflects approaches that are accepted, used in one or more other states, and applicable to other payers so as to make consistency across payers possible.
Resource-based: The payment system should result in payment calibrated to the expected use of resources and varying with acuity.
Simplicity: The payment system should minimize complexity and the costs associated with implementation (i.e., administrative burden to hospitals and payers.)

Lowest support
Outlier recognition: The payment system should accommodate the infrequent but significant variation in the resources required to care for patients with similar diagnoses.
Comprehensiveness: The payment system should include all inpatient health care services except long-term and skilled nursing facility care

Roles and responsibilities for hospitals' financial status
Subsequent to the Medicaid-specific work, a sub-group of Task Force members examined commercial payment oversight options in the context of community hospitals' work. They produced the following observations that informed their recommendations to the full Task Force, which are included here as context.

[7] Task Force members pointed out that "fairness is in the eye of the beholder" – a payment system fair to whom? Some advocated that reimbursement should take into account a hospital's costs, and would not necessarily be calculated using a consistent methodology. Another perspective favored reimbursement that would be adequate to ensure system-wide access to services, rather than institution-specific reimbursement rates.

1. Task Force members agree that community hospitals have experienced negative cash flow attributable to many causes, including the policies and practices of public and private entities as well as hospitals' own policies and practices.

2. The status quo for payment to and operations of community hospitals (including service delivery mix) is not sustainable. Each financially-fragile community hospital causes significant disruption for patients, staff providers, and community health. The factors contributing to each hospital's financial performance are multi-faceted. Hospitals' different internal systems for accounting for costs and revenue make in depth service product-line profitability analyses difficult to compare across hospitals.

3. It is difficult to define how the services of hospitals in a community can and should change in the absence of a public, long-term assessment of the community's need for health services and available supplies, and reliable information on hospital finances and insurer/payor payment policies.

4. Final responsibility for the future of an institution rests with its board and management. The state's role is in monitoring hospital quality, measuring financial performance, and evaluating other conditions of licensure (Department of Health); monitoring charitable assets of non-profits (Attorney General); directing health plans towards "fair treatment of providers" (Office of Health Insurance Commissioner); purchasing and paying for health care; and balancing policy priorities regarding hospitals with competing priorities within the state budget.

Recommendations and Findings

This report presents recommendations in five broad categories:

I.) Medicaid payment methodology;
II.) Commercial payment reform;
III.) Financial and payment transparency and analysis;
IV.) Health planning;
V.) Community hospital stabilization and transformation.
VI.) Licensing Fees

I. Medicaid payment methodology

A. The Task Force recommends that Rhode Island's FFS Medicaid program adopt a case-based method of payment for hospital inpatient stays. Further design and implementation planning should be done by DHS in collaboration with appropriate hospital personnel.

Specific recommendation:

1. *Of all DRG groupers, the APR-DRG grouper best captures the variation in resource use for individuals with different levels of severity but the same diagnosis in the Medicaid*

population, and should be considered as the basis for a case-based payment methodology.[8]

B. The Task Force recommends that the Department of Human Services use policy levers to modify the selected DRG grouper to address RI-specific concerns on access.

Specific recommendations:

1. *RI Medicaid's policy adjusters should be calibrated to be sufficient to maintain Medicaid FFS access for mental health and neo-natal care.*
2. *Minimize adverse financial impact of any change in payment methodology to non-teaching community hospitals (Kent, Landmark, Newport, St. Joseph's, South County, Westerly) as a group.*

C. The Task Force recommends that Medicaid FFS inpatient payments should include value-based purchasing (pay-for-quality), using evidence-based measures and an oversight process both developed by the Health Care Quality Performance Measurement and Reporting Program at the Department of Health.

D. The Task Force recommends sufficient time and resources should be allocated to the Department of Human Services for designing and implementing a DRG-based payment system.

E. The Task Force recommends that there should be an annual review of the base rate to be used by Medicaid in a DRG-based system.

F. The Task Force recommends that Medicaid should revise its outpatient payment method as well to create incentives consistent with a revised inpatient payment method.[9]

II. Commercial payment reform

[8] This is the finding of the ACS consultants to DHS and supported by the majority of the Task Force; other Task Force members put forward alternative suggestions for a DRG grouper.

[9] Some Task Force members felt that outpatient payment methodology should be revised at the same time as inpatient payment methodology, but resource constraints at DHS and recommendations from consultants based on their experience in implementing new payment systems led others to the opinion that the outpatient payment methodology should be studied, designed, implemented, and tested in sequence.

A. **The Task Force recommends that the current private negotiation process between hospitals and health plans evolve to one that more directly incents and rewards the goals of access, quality, efficiency, and appropriate distribution of services.**[10]
   - Although the Task Force considered a wide range of options for changing elements of the process of negotiation between hospitals and commercial payers, and there was scattered support for various options, no consensus could be achieved among the task force members for any change in commercial negotiation process.
   - One element of negotiation between hospitals and payers is payment method, and the Task Force did not support voluntary or mandatory actions to make payment methodologies more consistent and thus more comparable across payers (i.e., Medicare, Medicaid FFS, and commercial payers.)
   - In a presentation to the Task Force, the State's RIte Care program (Medicaid managed care) stated that they do not generally prescribe to contracted health plans the payment methodology they should use to pay providers, and they also would not support any change in payment methodology that would increase payments to hospitals beyond what health plans pay hospitals using their current methodology.

III. Financial and Payment Transparency and Analysis

Absent payment changes in commercial payment methodology, the Task Force recommends:

A. **The Department of Health should revise its regulations to identify specific financial statuses that would trigger greater oversight of the financial health of hospitals, similar to the insurance examination law.**
B. **The Department of Health should receive more resources to conduct more rigorous annual analyses of hospitals' financial and utilization trends and take appropriate actions consistent with its statutory responsibilities.**
C. **The Office of the Health Insurance Commissioner (OHIC) should conduct periodic analyses of rates of payment by commercial payers to hospitals, physicians and other providers, with relevant comparisons to adjacent states and public payers and take appropriate actions consistent with its statutory responsibilities.** [11]
   - These analyses will result in findings, insurer-specific findings reported only to the insurer itself (for information deemed proprietary), and potentially form the basis for regulatory action.

IV. Health Planning

A. **The Task Force recommends establishing a process for long-term health planning and its funding.**

---

[10] This recommendation is consistent with the recommendations of the Task Force's first report, i.e., a) the new payment methodology should include pay-for-performance provisions; b) payment should support primary care infrastructure and realign incentives to remove any reimbursement bias for complex services; c) changes in payment should ensure that incentives are sufficient to support low-complexity and preventive services that are effective contributors to health; d) changes in payment should be used to align financially the interests of hospitals and physicians and thus eliminate some of the competition between them. The Task Force did not address how this evolution would take place and the role of state government in the process.

[11] Concerns were expressed about the costs to the commercial payers of these analyses.

Specific recommendations:

1. *Department of Health leadership, and designated health plan and hospital leadership, should prioritize this initiative.*
2. *Members of the Health Care Planning and Accountability Advisory Council and/or interested members of the community should seek private/public funding to support this activity.*
3. *Using funds raised for this purpose, consultants to Department of Health and the Health Care Planning and Accountability Advisory Council should implement the Health Planning legislation (RIGL 23-81), with immediate attention to addressing the question of what facilities and services are needed given the geography and population of Rhode Island, with an eventual plan for restructuring hospitals and hospital services, as well as other facilities and services, to meet those needs.*

V. Community Hospital Stabilization and Transformation

A. The Task Force recommends that the Department of Health, in collaboration with the Office of the Health Insurance Commissioner and Department of Human Services, upon the request of a hospital board, should participate in a team convened by the hospital to examine the underlying reasons for the financial challenges faced by the hospital and determine what actions are appropriate. Where appropriate, the Department of Health may request the participation of other parties.

VI. Licensing Fees

A. The Task Force recommends that given the fragile financial condition of many hospitals, public officials should reconsider and reverse budget proposals to increase "licensing fees" for hospitals as a means of raising revenue.

Acknowledgements

This concludes the work of the Community Hospital Task Force. The co-chairs thank the members of the Task Force for attending to the Task Force's charge and the myriad of issues facing community hospitals in Rhode Island. Divergent points of view were expressed on key issues, and there was great difficulty in reaching consensus on the specifics of Medicaid payment redesign and oversight of hospital/health plan negotiation process, transparency of hospital payment rates, and short-term hospital stabilization. Given that these recommendations do not represent unanimous positions, rather than being a complete policy document, this report should be viewed instead as a platform for continuing dialogue on short- and long-term strategies.

The co-chairs also thank the consultants and staff for their assistance in informing the Task Force's work. Finally, the co-chairs thank the Governor and Lieutenant Governor for the opportunity to serve and hope these recommendations are of use.